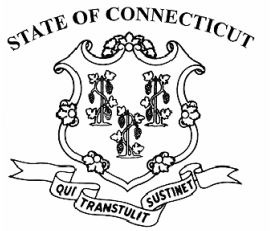

Substitute Senate Bill No. 46

Public Act No. 09-46

AN ACT CONCERNING THE CONSUMER REPORT CARD.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-478*l* of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2009*):

(a) Not later than **[**March 15, 1999, and annually thereafter**]** October fifteenth of each year, the Insurance Commissioner, after consultation with the Commissioner of Public Health, shall develop and distribute a consumer report card on all managed care organizations. The commissioner shall develop the consumer report card in a manner permitting consumer comparison across organizations.

(b) The consumer report card shall be known as the "Consumer Report Card on Health Insurance Carriers in Connecticut" and shall include (1) all health care centers licensed pursuant to chapter 698a, (2) the fifteen largest licensed health insurers that use provider networks and that are not included in subdivision (1) of this subsection, **[**and**]** (3) the medical loss ratio of each such health care center or licensed health insurer, and (4) information concerning mental health services, as specified in subsection (c) of this section. The insurers selected pursuant to subdivision (2) of this subsection shall be selected on the basis of Connecticut direct written health premiums from such

network plans. For the purposes of this section and section 2 of this act, and sections 38a-478c, as amended by this act, and 38a-478g, as amended by this act, "medical loss ratio" means the ratio of incurred claims to earned premiums for the prior calendar year for managed care plans issued in the state. Claims shall be limited to medical expenses for services and supplies provided to enrollees and shall not include expenses for stop loss coverage, reinsurance, enrollee educational programs or other cost containment programs or features.

(c) With respect to mental health services, the consumer report card shall include information or measures with respect to the percentage of enrollees receiving mental health services, utilization of mental health and chemical dependence services, inpatient and outpatient admissions, discharge rates and average lengths of stay. Such data shall be collected in a manner consistent with the National Committee for Quality Assurance Health Plan Employer Data and Information Set (HEDIS) measures.

(d) The commissioner shall test market a draft of the consumer report card prior to its publication and distribution. As a result of such test marketing, the commissioner may make any necessary modification to its form or substance. The Insurance Department shall prominently display a link to the consumer report card on the department's Internet web site.

Sec. 2. (NEW) (*Effective October 1, 2009*) An insurer or health care center shall include a written notice with each application for individual or group health insurance coverage that discloses such insurer's or health care center's medical loss ratio, as defined in subsection (b) of section 38a-478*l* of the general statutes, as amended by this act, as reported in the last Consumer Report Card on Health Insurance Carriers in Connecticut, to an applicant at the time of application for coverage.

Sec. 3. Subsection (a) of section 38a-478c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2009*):

(a) On or before May **[**1, 1998, and annually thereafter**]** first of each year, each managed care organization shall submit to the commissioner:

(1) A report on its quality assurance plan that includes, but is not limited to, information on complaints related to providers and quality of care, on decisions related to patient requests for coverage and on prior authorization statistics. Statistical information shall be submitted in a manner permitting comparison across plans and shall include, but not be limited to: (A) The ratio of the number of complaints received to the number of enrollees; (B) a summary of the complaints received related to providers and delivery of care or services and the action taken on the complaint; (C) the ratio of the number of prior authorizations denied to the number of prior authorizations requested; (D) the number of utilization review determinations made by or on behalf of a managed care organization not to certify an admission, service, procedure or extension of stay, and the denials upheld and reversed on appeal within the managed care organization's utilization review procedure; (E) the percentage of those employers or groups that renew their contracts within the previous twelve months; and (F) notwithstanding the provisions of this subsection, on or before July 1, 1998, and annually thereafter, all data required by the National Committee for Quality Assurance (NCQA) for its Health Plan Employer Data and Information Set (HEDIS). If an organization does not provide information for the National Committee for Quality Assurance for its Health Plan Employer Data and Information Set, then it shall provide such other equivalent data as the commissioner may require by regulations adopted in accordance with the provisions of chapter 54. The commissioner shall find that the requirements of this

subdivision have been met if the managed care plan has received a one-year or higher level of accreditation by the National Committee for Quality Assurance and has submitted the Health Plan Employee Data Information Set data required by subparagraph (F) of this subdivision.

(2) A model contract that contains the provisions currently in force in contracts between the managed care organization and preferred provider networks in this state, and the managed care organization and participating providers in this state and, upon the commissioner's request, a copy of any individual contracts between such parties, provided the contract may withhold or redact proprietary fee schedule information.

(3) A written statement of the types of financial arrangements or contractual provisions that the managed care organization has with hospitals, utilization review companies, physicians, preferred provider networks and any other health care providers including, but not limited to, compensation based on a fee-for-service arrangement, a risk-sharing arrangement or a capitated risk arrangement.

(4) Such information as the commissioner deems necessary to complete the consumer report card required pursuant to section 38a-478*l*, as amended by this act. Such information may include, but need not be limited to: (A) The organization's characteristics, including its model, its profit or nonprofit status, its address and telephone number, the length of time it has been licensed in this and any other state, its number of enrollees and whether it has received any national or regional accreditation; (B) a summary of the information required by subdivision (3) of this section, including any change in a plan's rates over the prior three years, its medical loss ratio, **[**or percentage of the total premium revenues spent on medical care compared to administrative costs and plan marketing**]** as defined in subsection (b) of section 38a-478*l*, as amended by this act, how it compensates health care providers and its premium level; (C) a description of services, the

number of primary care physicians and specialists, the number and nature of participating preferred provider networks and the distribution and number of hospitals, by county; (D) utilization review information, including the name or source of any established medical protocols and the utilization review standards; (E) medical management information, including the provider-to-patient ratio by primary care provider and speciality care provider, the percentage of primary and speciality care providers who are board certified, and how the medical protocols incorporate input as required in section 38a-478e; (F) the quality assurance information required to be submitted under the provisions of subdivision (1) of subsection (a) of this section; (G) the status of the organization's compliance with the reporting requirements of this section; (H) whether the organization markets to individuals and Medicare recipients; (I) the number of hospital days per thousand enrollees; and (J) the average length of hospital stays for specific procedures, as may be requested by the commissioner.

(5) A summary of the procedures used by managed care organizations to credential providers.

Sec. 4. Section 38a-478g of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2009*):

(a) Each managed care contract delivered, issued for delivery, renewed, amended or continued in this state **[**on or after October 1, 1997,**]** shall be in writing and a copy thereof furnished to the group contract holder or individual contract holder, as appropriate. Each such contract shall contain the following provisions: (1) Name and address of the managed care organization; (2) eligibility requirements; (3) a statement of copayments, deductibles or other out-of-pocket expenses the enrollee must pay; (4) a statement of the nature of the health care services, benefits or coverages to be furnished and the period during which they will be furnished and, if there are any

services, benefits or coverages to be excepted, a detailed statement of such exceptions; (5) a statement of terms and conditions upon which the contract may be cancelled or otherwise terminated at the option of either party; (6) claims procedures; (7) enrollee grievance procedures; (8) continuation of coverage; (9) conversion; (10) extension of benefits, if any; (11) subrogation, if any; (12) description of the service area, and out-of-area benefits and services, if any; (13) a statement of the amount the enrollee or others on his behalf must pay to the managed care organization and the manner in which such amount is payable; (14) a statement that the contract includes the endorsement thereon and attached papers, if any, and contains the entire contract; (15) a statement that no statement by the enrollee in his application for a contract shall void the contract or be used in any legal proceeding thereunder, unless such application or an exact copy thereof is included in or attached to such contract; and (16) a statement of the grace period for making any payment due under the contract, which shall not be less than ten days. The commissioner may waive the requirements of this subsection for any managed care organization subject to the provisions of section 38a-182.

(b) Each managed care organization shall provide every enrollee with a plan description. The plan description shall be in plain language as commonly used by the enrollees and consistent with chapter 699a. The plan description shall be made available to each enrollee and potential enrollee prior to the enrollee's entering into the contract and during any open enrollment period. The plan description shall not contain provisions or statements that are inconsistent with the plan's medical protocols. The plan description shall contain:

(1) A clear summary of the provisions set forth in subdivisions (1) to (12), inclusive, of subsection (a) of this section, subdivision (3) of subsection (a) of section 38a-478c, as amended by this act, and sections 38a-478j to 38a-478*l*, inclusive, as amended by this act;

(2) A statement of the number of managed care organization's utilization review determinations not to certify an admission, service, procedure or extension of stay, and the denials upheld and reversed on appeal within the managed care organization's utilization review procedure;

(3) A description of emergency services, the appropriate use of emergency services, including to the use of E 9-1-1 telephone systems, any cost sharing applicable to emergency services and the location of emergency departments and other settings in which participating physicians and hospitals provide emergency services and post stabilization care;

(4) Coverage of the plans, including exclusions of specific conditions, ailments or disorders;

(5) The use of drug formularies or any limits on the availability of prescription drugs and the procedure for obtaining information on the availability of specific drugs covered;

(6) The number, types and specialties and geographic distribution of direct health care providers;

(7) Participating and nonparticipating provider reimbursement procedure;

(8) Preauthorization and utilization review requirements and procedures, internal grievance procedures and internal and external complaint procedures;

(9) The medical loss ratio, **[**or percentage of total premium revenue spent on medical care compared to administrative costs and plan marketing**]** as defined in subsection (b) of section 38a-478*l*, as amended by this act, as reported in the last Consumer Report Card on Health Insurance Carriers in Connecticut;

(10) The plan's for-profit, nonprofit incorporation and ownership status;

(11) Telephone numbers for obtaining further information, including the procedure for enrollees to contact the organization concerning coverage and benefits, claims grievance and complaint procedures after normal business hours;

(12) How notification is provided to an enrollee when the plan is no longer contracting with an enrollee's primary care provider;

(13) The procedures for obtaining referrals to specialists or for consulting a physician other than the primary care physician;

(14) The status of the National Committee for Quality Assurance (NCQA) accreditation;

(15) Enrollee satisfaction information; and

(16) Procedures for protecting the confidentially of medical records and other patient information.

Approved May 20, 2009